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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 2/25/15

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Bilateral SI Joint Injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified Pain Management & Anesthesiology

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
Overturned	**(Disagree) X**
Partially Overturned	(Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY
Patient is a male who sustained an injury in xx/xxxx as he was picking up a heavy, glass table. A number of helpful treatment modalities have been utilized. He has had a lumbar laminectomy in L3-4 and a fusion in L4-5 and L5-S1. Office notes indicate that on physical exam there was positive Fortin finger test and positive Faber test. Patient has been prescribed home exercise twice.

PATIENT CLINICAL HISTORY SUMMARY (continuation)
submitted a letter of medical necessity (2/05/15) which described extensive medication and therapy notes. He provided adequate documentation of failure of conservative measures.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION
Opinion:
I disagree with the benefit company's decision to deny the Bilateral SI Joint Injection.

Rationale: Official disability guidelines stipulate there should be three positive exam findings, which are present; there should be documentation of failure of conservative therapy. The ODG guidelines are met for the requested bilateral SI joint injection.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)